



New York State Correctional Officers & Police Benevolent Association, Inc.

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- PLEASE POST -

TO: Chief Sector Stewards With Binding Arbitration
FROM: Sharon Smith, Health Benefits Specialist
DATE: June 23, 2009
RE: Health Insurance Updates

Below is a list of benefit updates concerning your membership's health insurance coverage. Please post this memo to help remind them of the changes.

All Members:

Dependent Eligibility Verification Project – Phase 1 of this project is complete and Budco has begun Phase 2 (runs from 7/6/09 through 10/5/09). The eligibility verification packets will be mailed July 2-10, 2009. **Every** member with family coverage is mandated to respond to the packet and forward the required eligibility verification documents to Budco (**DO NOT SEND ORIGINAL DOCUMENTS, ONLY COPIES – BUDCO WILL NOT RETURN ANY DOCUMENTS SUBMITTED**). **If a member does not respond, their dependents will be removed from coverage effective 2/1/09** (the starting point of this project). All questions should be directed to Budco (not your Personnel Office) – they have direct contact with Civil Service and will help members with all issues. Budco's telephone number (through July 2nd) is 1-888-358-2196. Effective July 3rd, Budco's number will be 1-888-358-2198.

Effective 7/1/09, any permanent, full-time employee removed from payroll due to an assault (as described in Article 14.9) and who is granted workers' compensation for up to 24 months, will remain covered under the State Health Insurance Plan for the same duration and be responsible for the employee share of their premium only.

Effective 7/1/09, covered dependent students shall be provided with a 3-month extended benefit period upon completion of each semester as a covered full-time student (or equivalent).

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Members Enrolled in the Empire Plan:

Effective the date of the arbitration award (4/30/09), the Basic Medical provider Discount Program is extended until 12/31/11.

Effective 7/1/09, your copayments associated with participating provider office visits and office surgery, as well as laboratory and x-ray services, will increase from \$18 to \$20. This includes similar services for mental health services under the Mental Health and Substance Abuse Program.

Effective 7/1/09, the copayment for surgeries performed at either facilities certified under Article 28 or accredited by one or more of the recognized organization, such as JCAHO (Joint Commission on Accreditations of Healthcare Organizations) (i.e., participating ambulatory care facilities) will increase from \$15 to \$30.

Effective 7/1/09, the copayment for a non-preferred brand drug (Tier III drug) will increase from \$30 to \$40 for up to a 30-day supply (retail and mail), from \$60 to \$70 for a 31-90 day supply (retail), and from \$55 to \$65 for a 31-90 day supply (mail order). There are no copayment increases for Tier I (generic) and Tier II (preferred) drugs.

Effective 7/1/09, a disease management programs for depression will be implemented Effective 7/1/09, or as soon as practicable thereafter, disease management programs for eating disorders (including appropriate nutritional services) and ADHD will be implemented.

Effective 7/1/09, coverage for adult immunizations under the participating provider program (not covered under the basic medical program) shall include the Herpes Zoster (Shingles) vaccine for those age 55 and older.

Effective 7/1/09, an annual diabetic shoe benefit will be available through the Home Care Advocacy Program of United HealthCare. The benefit provides coverage for one pair of custom molded or depth shoes per calendar year if (1) the member has a diagnosis of diabetes and diabetic foot disease; (2) diabetic shoes have been prescribed by a physician; and (3) they are fitted and furnished by a qualified perdorthist, orthotist, prosthetist or podiatrist. Shoes ordered from the internet or by mail are not eligible for benefits. In-network coverage will be a paid-in-full benefit up to a \$500 maximum. **A pre-notification call must be made to the HCAP Program, which will assist in making arrangements to receive network benefits.** For non-network coverage, reimbursement will be under the Basic Medical Program, subject to deductible, with the remainder paid at 75% of the network allowance (up to a maximum allowance of \$500).

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Effective 7/1/09, prosthetic wigs shall be a covered basic medical benefit and reimbursed up to a lifetime maximum of \$1500 (regardless of the number of wigs), not subject to deductible or coinsurance. Hair loss must be due to an acute or chronic condition that leads to hair loss; male and female pattern baldness is excluded.

Effective 7/1/09, or as soon as practicable thereafter, United HealthCare shall include a network of Diabetes Education Centers accredited by the American Diabetes Education Recognition Program to provide services regarding nutrition and lifestyle improvements. Visits to a participating center will require an office visit copayment for each covered service. Services at a non-participating center will be considered under the Basic Medical Program, subject to deductible and coinsurance.

Effective 7/1/09, or as soon as practicable, a disease management program for chronic kidney disease will be implemented under United HealthCare.

Effective 7/1/09, the travel allowance for the Centers of Excellence Programs shall be modified to reimburse meals and lodging at the Federal Government rate. Additionally, the lifetime maximum for travel and lodging expenses for the Cancer Resource Services Program is eliminated.

Effective 7/1/09, the Prospective Procedure Review presently in effect for outpatient MRIs will be expanded to include a Magnetic Resonance Angiography (MRA), computed tomography (CT), Positron Emission Tomography (PET) Scans and nuclear medicine diagnostic procedures when performed as an elective (scheduled) procedure at the outpatient department of a hospital, a participating provider office or a freestanding clinic. **Failure to call for medically-necessary services prior to obtaining the services will result in members being responsible for paying the lesser of 50% of the scheduled amounts related to the procedure or \$250, plus their copayment. If performed by a non-participating provider and not certified, the member is liable for the lesser of 50% of the reasonable and customary charges related to the procedure or \$250, plus their annual deductible and any amount above the reasonable and customary charge. If the procedure is deemed not medically necessary, the member will be responsible for the full cost of the procedure.**

Effective 7/1/09, language under the Home Care Advocacy Program for the purchase of Durable Medical Equipment will be modified to provide that benefits are available for the most cost-effective equipment as meets the patient's functional need and that benefits are provided for a single unit of equipment and repair or replacement as necessary.

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Effective 1/1/10, the Basic Medical coinsurance maximum will be calculated separately from the deductible. The out-of-pocket maximum will be \$800 for the enrollee, \$800 for the member's spouse/domestic partner, and \$800 for all dependent children combined. This change also applies to mental health coverage under the Mental Health and Substance Abuse Program.

Effective 1/1/10, the Prescription Drug Administrator has discretion and flexibility to move drugs within the various tiers of the formulary ("Flexible" Formulary). A drug moved to a higher or lower tier will have the same copayment as other drugs in that tier. Some drugs presently covered may be removed from the formulary altogether (and no longer covered) if there is a clinically sound and therapeutically equivalent Tier 1 option or other covered drug within its class, or where the drug or drug comprised of its components are available in an over-the-counter form or equivalent.

Effective 1/1/10, a Corrective Vision Care benefit is available for **members only** through EyeMed Vision Care and a network of participating ophthalmologists. Coverage provides Lasik and other corrective vision care procedures performed to correct nearsightedness and/or farsightedness not covered under the Empire Plan or an HMO. This benefit includes a preliminary exam, the actual procedure and up to two follow-up visits. Members will have a copayment equal to 10% of the discounted cost of the procedure, up to an out-of-pocket maximum of \$200. They are eligible for one Corrective Vision Care Procedure every 5 years per eye, but the five (5) year limit may be waived based on evidence of a significant vision change due to injury or illness. Member dependents will continue to receive the discount benefit for such services (up to a 25% discount with participating providers and responsible for any and all costs associated with such procedures).

Effective 1/1/10, the maximum reimbursement for non-network inpatient and outpatient hospital services under the basic medical component will be reduced from \$1500 to \$1000.

Effective 1/1/10, or as soon as practicable thereafter, an Empire Plan Specialty Drug Program will be implemented, consisting of a network of one or more specialty pharmacies which must be used to obtain specialty drugs (after the initial fill). Members will be provided with 24/7/365 access to a pharmacist. Excluded drugs will include those identified for short-term therapy, for which a delay in starting therapy would affect clinical outcome. Specialty drugs will be limited to a 30-day supply.

Feel free to contact me with any questions you might have.

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cc: NYSCOPBA Executive Board
NYSCOPBA Jt. Committee on Health Benefits